PROVIDER REIMBURSEMENT GUIDANCE

Claims Reconsideration

Original Date Approved	Effective Date SCO/ICO	Effective Date MAPD*	Revision Date
8/06/2017	10/01/2017	01/01/2022	10/25/2021

Scope: Commonwealth Care Alliance (CCA) Product Lines

☒ Senior Care Options (MA)
☒ One Care (MA)
☒ CCA Medicare Preferred – (PPO) MA*
☒ CCA Medicare Value - (PPO) MA*
☒ CCA Medicare Preferred – (PPO) RI*
☒ CCA Medicare Value - (PPO) RI*
☒ Medicare Maximum – (HMO DNSP) RI*

PAYMENT POLICY SUMMARY:

Providers can file a claim(s) reconsideration request when the provider disagrees with a claim decision regarding reimbursement or denial. CCA will require that all claim reconsideration requests be made in writing and follow the time frames outlined in this policy.

CCA will consider payment disputes and adjustment requests for:

- Level of reimbursement, compensation, and all denials except filing limits, for up to 90 days from the original adjudication date.
- Filing limit appeals and corrected claim(s) will be considered within 90 days from original denial date with supporting documentation.
- Corrected claims for Medicare lines of business (CCA Medicare Preferred, Medicare Value and Medicare Maximum) will be accepted through the timely filing period.

Medicare Advantage: The provider or the member's representative has the right to file a Level I Appeal (Reconsideration) on behalf of the member for an item or service denied in part or whole.

Level I appeal can be expedited at the request of the physician and can be done verbally. Non expedited requests must be received in writing.

Reconsiderations must be received within 60 calendar days from the date of notice of determination.

CLAIMS RECONSIDERATION REQUEST PROCESS:

How to Submit a Provider Reconsideration Request:

Providers who have an inquiry or dispute related to reimbursement, adjudication, or denial of a claim can submit a claim(s) reconsideration request to the address listed in the provider manual for their respective state where the services took place.

Requests must include a copy of the EOP, appropriate documentation according to the dispute, and a completed Request for Claim Review form. Each claim should have its own individual Request for Claim Review form.

Claims reconsideration requests sent without the required documentation, will be rejected and sent back to the provider without being reviewed.

- Non-Contracted providers must also include a signed Waiver of Liability form in addition to the required information outlined within this policy. Without this form, the reconsideration request will be dismissed.
- The request for Claim Review form can be found at the Healthcare Administrative Solutions Inc (HCAS) website Request for Claim Review; as well as in the CCA Provider Manual

Required Documentation:

Claims Denied for Lack of Prior Authorization or Inpatient Notification

- Claim review form
- Typed letter of appeal
- Copy of the claim
- Copy of the EOP
- Other pertinent information; an explanation as to why the proper procedure to obtain other inpatient notification or prior authorization were not obtained

Compensation/Contractual Reimbursement Appeals:

- Claim review form
- EOP
- A concise explanation for which the provider believes the payment amount, request for additional information, or other CCA action is incorrect

- Original claim
- NOTE: For fee adjustment requests, please submit all supporting documentation including: invoices, operative notes, office notes, radiology/pathology reports, and all other supporting documentation pertinent to the provider appeal request

Appeals for the Unlisted Procedure code Denials:

- Claim review form
- EOP
- Operative notes that are highlighted to identify the service performed and other supporting documentation for the unlisted code
- A concise explanation of the unlisted procedure performed and a comparable procedure code for reimbursement of this procedure
- NOTE: Providers submitting unlisted or miscellaneous drug codes not currently covered by a HCPCS code must include an invoice that includes the drug name, appropriate National Drug Code (NDC) number and dosage. -*See reference listed to the FDA website*
- If an unlisted code is submitted for a procedure/drug there is already an active CPT/HCPCS code for, the unlisted procedure/drug code will be denied

CCA reserves the right to deny claims that do not include sufficient documentation during the reconsideration process. Documentation included should always substantiate the services rendered. If claims for unlisted procedure codes are submitted without following the documentation requirements above, the claim will be denied. Claims reconsideration should always include a narrative with rationale for why the provider believes the claim should be reimbursed.

LIMITATION OF THE CLAIMS RECONSIDERATION PROCESS:

Claims reconsideration requests received after the policy timeframe (90 days for payment disputes, adjustment requests, and filing limit requests.) will not be considered. Network providers, certain plans, products, and delegated arranged contracts may have specific filing deadlines that require additional information listed in the provider contract that could conflict with policy guidelines. When this occurs, the contract dictates the filing deadline. Refer to the member specific benefit plan document or Evidence of Coverage to determine whether coverage is provided or if there are any exclusions and/or benefit limitations. If there is a difference between any policy and the member specific document or Evidence of Coverage, the member specific document or Evidence of Coverage will govern. If a provider reconsideration does not include all required information listed above, it will be returned to the provider for completion. If the same reconsideration is not returned with the required information within 60 days, the reconsideration will be dismissed.

DISCLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable and adherence to plan policies and procedures and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

REFERENCES:

CMS Website:
https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-MedicaidCoordination.html

CCA Website:
http://www.commonwealthcarealliance.org

Healthcare Administrative Solutions Website: https://www.hcasma.org

Food and Drug Administration Website:
https://www.fda.gov/drugs

National Correct Coding Initiative:
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

POLICY TIMELINE DETAILS

1. Approved August 2017
2. October 2017 effective
3. Revised August 2019 Corrected filing limit for appeals date & format revision
4. Revised October 2021 revised scope; added MAPD detail


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